PRINTED: 04/09/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	00	COMPLETED	
155200		B. WING		03/08/2013	
NAME OF P	ROVIDER OR SUPPLIEF	₹		ADDRESS, CITY, STATE, ZIP CODE	
				UNIVERSITY BLVD	
UNIVERS	SITY NURSING CE	NTER	UPLAN	ID, IN 46989	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	·	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F000000					
	This visit was for	the Investigation of	F000000	Dear Ms. Rhoades, Attached	ie
		the Investigation of	1 000000	University Nursing Center's Pl	
	Complaint IN0012	24856.		of Correction for Complaint	
				IN00124856 Survey on March	
	Complaint			2013. Please accept the Pla Correction for the deficiency o	
	IN00124856-Subs	stantiated,		0309, SS D. University Nursir	
	Federal/State def	iciency related to the		Center is requesting paper	
	allegattion is cited			compliance for the deficiency.	
				Thank you, Stephanie Allen Executive Director University	
				Nursing Center	
	Survey Dates: March 7 & 8, 2013				
	Facility number: 000107				
	Provider number: 155200 AIM number: 100290330				
	Survey team:				
	-	A.I.			
	Angela Strass, RI	V			
	Census bed type:				
	SNF/NF: 49				
	Total: 49				
	Census payor typ	e:			
	Medicare: 4	~ ·			
	Medicaid: 35				
	Other: 10				
	Total: 49				
	Sample: 3				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/09/2013 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155200		(X2) MULTIPLE CC A. BUILDING B. WING	00	COM	PLETED 98/2013	
NAME OF PROVIDER OR SUPPLIER UNIVERSITY NURSING CENTER			STREET A 1564 S	ADDRESS, CITY, STATE, ZIP UNIVERSITY BLVD D, IN 46989		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	This deficiency als findings in accord 16.2.	so reflects state ance with 410 IAC				
	Quality review cor 13, 2013 by Rand	•				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: Q2DX11

Facility ID: 000107

If continuation sheet

Page 2 of 6

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/09/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155200		(X2) MULTIPLE CONSTRUCTION A. BUILDING D. WING			(X3) DATE : COMPL	ETED	
		155200	B. WIN			03/08/	2013
NAME OF PROVIDER OR SUPPLIER UNIVERSITY NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1564 S UNIVERSITY BLVD UPLAND, IN 46989				
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
F000309 SS=D	must provide the services to attain practicable physic psychosocial well the comprehensive care. Based on record reinterview, the facility resident A) in a service reviewed, restorative nursing consistently as well residents plan of comprehensive consistently as well residents. On 3/7/13 at 10:48 clinical record for reindicated the residents plan of comprehensive consistently as well residents. On 3/7/13 at 10:48 clinical record for reindicated the residents plan of comprehensive consistently as well residents. On 3/7/13 at 10:48 clinical record for reindicated the residents plan of comprehensive consistently as well residents.	BEING st receive and the facility necessary care and or maintain the highest cal, mental, and -being, in accordance with re assessment and plan of eview and dity failed to ensure sample of 3 resident received a g program ditten by the eare. 5 a.m. review of the resident (A) lent was admitted to /13 with diagnoses mited to reporosis and re Pulmonary of the resident's minimum data set) 1 /1/18/13 indicated red extensive	F00	0309	What corrective action will be accomplished for those residents found to have been affected by the deficient practice: The residents found have been affected by the deficient practice will have the restorative programs audited of for compliance by the MDS Coordinator or designee. MDS coordinator or designee will alse ensure that restorative program are correctly written. The resident affected has been see per program unless resident herefused, which is indicated on restorative program has been rewritten to reflect ambulation with assist (attachment A). How other to be affected by the same deficient practice will be identified and what corrective action will be taken: All residents who are on restorative programs have the potential to affected. All residents on restorative programs will be audited by the MDS Coordinator designee to ensure residents	to daily Sooms en as the see r al	04/07/2013

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: Q2DX11

Facility ID: 000107

If continuation sheet Page 3 of 6

PRINTED: 04/09/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 00			COMPLETED	
155200			B. WIN	G		03/08/2013
NAME OF PROVIDER OR SUPPLIER				STREET A	ADDRESS, CITY, STATE, ZIP CODE	
					UNIVERSITY BLVD	
UNIVERS	SITY NURSING CE	NTER		UPLAN	D, IN 46989	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION
TAG	G REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG		5.112
					are being seen as the program written. Nursing staff will be	1 IS
	On 3/8/13 at 9:30	a.m. review of the			in-serviced to ensure	
	resident's restorat	ive nursing plan of			understanding and compliance	e of
	care dated 2/25/1	•			restorative programs by the SI	
	following:				or designee. DNS or designee will ensure residents who are o	
	ioliowing.				restorative therapy will recieve	
					therapy per plan of care. MDS	
	Resident will perfo	orm 20 repetitions of			coordinator or designee will	
	active range of mo	otion to the BUE			ensure that restorative prograr are reviewed to ensure that	ns
	(bilateral upper ex	tremities) and BLE			assistance is reflected on the	
	(bilateral lower ex	tremities) daily.			restorative program. MDS	
	Resident will walk 150 feet using a rolling walker, gait belt and wheel chair to follow for safety, with assist of 1 daily.				coordinator was inserviced by	RAI
					specialist on 3/18/13 regarding	
					restorative (see attachment C) What measures will be p	
					, ut	
					practice does not recur: All	
	On 3/8/13 at 9:45	a.m. review of the			residents on restorative progra	ıms
	resident's "restora				will be audited daily for three months and weekly for six	
					months by the MDS Coordinate	or
		the resident had not			or designee to ensure resident	
	received services				are being seen as the program	ı is
	and 3/7/13. Interv	riew with the			written. Nursing staff will be in-serviced to ensure	
	restorative nursing	g aide on 3/8/13 at			understanding and compliance	e of
	9:50 a.m. indicate	d she was to			the restorative programs by the	e
	provide the service	es to the resident			SDC or designee on 3/25/13 (s	
	-				attachment D). MDS coordina or designee will audit restorative	
	daily but another restorative aide had quit 2 weeks ago and she was unable to provide services daily to the				programs weekly for six month	
					to ensure that restorative	
					programs are reviewed to ensu that assistance is reflected on	
	resident and was	trying to do it every			restorative program. DNS or	uic
	other day.				designee will conduct rounds	
					daily to ensure residents who	
					I .	ı

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/09/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
and Plan of Correction identification number: 155200		A. BUILDING 00		00	03/08/2013	
		133200	B. WIN			03/00/2013
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE UNIVERSITY BLVD	
UNIVERSITY NURSING CENTER					D, IN 46989	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	<i>'</i> I	(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
	On 3/8/13 at 10:00 a.m. interview with				receive restorative therapy are	
	the Administrator	indicated a			being seen per plan of care. How the corrective actions	
	restorative aide had walked off of the				will be monitored to ensure	the
	job 2 weeks ago.	She indicated the			deficient practice does not recur: All residents on	
	CNA'S are helping	g out with the			restorative programs will be	
	restorative progra	m.			audited daily for three months	
					and weekly for six months by MDS Coordinator or designee	
	On 3/8/13 at 10:20	0 a.m. interview with			ensure residents are being se	
	CNA (certified nur	rsing assistant) #1,			as the program is written with	
	who works with th	e resident on a daily			results to CQI. Nursing staff vibe in-serviced to ensure	WIII
	basis, and works	7:00 a.m to 7:00			understanding and complianc	
	p.m., indicated re	esident (A) does not			the restorative programs by the SDC or designee on 3/25/13.	ne
	walk well and had been walking with				MDS coordinator or designee	will
	the therapy depar	tment. The CNA			audit restorative programs we for six months to ensure that	ekly
	was queried if she	e walked the			restorative programs are	
	resident or did act	tive range of motion			reviewed to ensure that correct	
	for the resident ar	nd she indicated no.			ADL assistance is reflected or the restorative program with	n
					results to CQI. Executive Dire	
	On 3/8/13 at 12:00	0 p.m. interview with			or designee will monitor MDS Coordinator or designee's	
	therapy staff #1 in	dicated the resident			auditing weekly to ensure	
	had received phys	sical therapy from			compliance (see attachment E If 95% threshold is not met on	
	1/12/13 through 2	/16/13 and then			any of the above indicators, a	n
	recommendations	were made for the			internal plan of correction will formed to ensure compliance.	
	resident to have a	restorative nursing			By what date the systemic	I
	program.				changes will be completed: April 7, 2013	
l	This Federal tag is related to					
	complaint IN0012					
	3.1-37(a)					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: Q2DX11

Facility ID: 000107

If continuation sheet

Page 5 of 6

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/09/2013 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 155200	(X2) MULTIPLE CO A. BUILDING B. WING	00	COM	e survey PLETED 8/2013		
NAME OF PROVIDER OR SUPPLIER UNIVERSITY NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1564 S UNIVERSITY BLVD UPLAND, IN 46989					
	SITY NURSING CE SUMMARY S (EACH DEFICIEN				ECTION DULD BE PROPRIATE	(X5) COMPLETION DATE		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: Q2DX11

Facility ID: 000107

If continuation sheet

Page 6 of 6